THE REPRESSED MEMORY CONTROVERSY: IS THERE MIDDLE GROUND?

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Abstract • Résumé

To familiarize readers with the main issues in the debate over the veracity of long-hidden memories of childhood sexual abuse, information, arguments and hypotheses from the medical and social-science literature are examined. The author reviews the challenge presented by those who propose that all or most memories of past sexual abuse recovered during therapy are false, the response of those who contend that these memories are valid and could not be manufactured by therapists, and the views of those with a more balanced approach who carefully examine all of the evidence and look for the middle ground. Although research in this area is in its infancy, available information suggests that both recovered and fabricated memories exist. Until further research helps to identify the difference between the two, physicians need to keep an open mind and offer support and understanding to both alleged victims and accused parents. Research is needed on (1) the extent of corroboration of recovered memories of sexual abuse, (2) the identification of memory mechanisms, specific situations and personality factors involved in forgetting and remembering traumatic events, and (3) the factors affecting traumatized patients during therapy, including memory performance and suggestibility.

Afin d'initier les lecteurs aux principaux aspects du débat sur la véracité de souvenirs réprimés d'abus sexuels subis au cours de l'enfance, on examine des renseignements, des arguments et des hypothèses tirés des écrits de la médecine et des sciences sociales. L'auteur passe en revue le défi que posent ceux qui affirment que l'ensemble ou la majeure partie des souvenirs d'abus sexuels subis dans le passé ramenés à la surface au cours de la thérapie sont faux, la réponse de ceux qui affirment que ces souvenirs sont valables et ne pourraient être fabriqués par des thérapeutes, et l'opinion de ceux qui adoptent une approche plus équilibrée, examinent attentivement toutes les données probantes et recherchent le moyen terme. Même si la recherche dans ce domaine en est à ses premiers pas, les renseignements disponibles indiquent qu'il existe à la fois des souvenirs retrouvés et des souvenirs fabriqués. En attendant que des recherches plus poussées aident à définir la différence entre les deux, les médecins doivent garder l'esprit ouvert et appuyer et comprendre à la fois les prétendues victimes et les parents accusés. Des recherches s'imposent sur (1) l'étendue de la corroboration des souvenirs retrouvés d'abus sexuel, (2) l'identification des mécanismes de la mémoire, des situations précises et des facteurs de personnalité qui interviennent dans l'oubli et le rappel d'événements traumatisants et (3) les facteurs qui affectent les patients traumatisés au cours de la thérapie, y compris la performance de la mémoire et la suggestibilité.

Community surveys conducted during the last two decades have indicated a hitherto unsuspected incidence of childhood sexual abuse in the general population.[1–3] At the same time, there has been a proliferation of professional[4–6] and self-help[7–10] literature dedicated to helping the victims (also called the "survivors") of this abuse. Growing attention is being paid to the victims with a "disguised presentation":[4] those with little or no memory of the abuse, whose history, constellation of symptoms and general behaviour alert the therapist or reader of self-help literature to the possibility of underlying abuse. It is postulated that children who suffer repeated sexual abuse,[11] intense, violent or life-threatening trauma,[12] or more than one type of abuse[13] are more likely to be unable to remember abuse than those abused less severely. Although anecdotal reports of recovered memories, some corroborated by other sources,[14] abound, research evidence of documented abuse being forgotten[15] or of recovered memories being corroborated[16] is slim and has been disparaged.[17,18]

In 1992 a group of concerned professionals and parents, convinced that many parents were being falsely ac-

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cused by their now-adult children, formed the False Memory Syndrome Foundation, which is based in Philadelphia. Two of the members of the foundation's professional advisory board, Elizabeth Loftus, a memory researcher, and Richard Ofshe, a sociologist, have spearheaded a massive attack on "recovered-memory therapists" who, they charge, have induced false memories in thousands of clients and destroyed the clients' innocent parents. In vitriolic attacks, Ofshe claims that the "recovered memory therapy epidemic . . . is fast being recognized as the major psychiatric quackery of the twentieth century."[19] Rebuttals have ranged from vigorous[20] to more reasoned examinations of the scientific evidence.[14,21] The debate and surrounding controversy have been reflected and reinforced in the news media, which are eager for this type of story.

How are physicians affected by this polemic? How should family physicians react to patients who claim that previously buried memories of abuse are beginning to emerge? What should they do when these patients want to be referred to therapists? Is hypnosis helpful or contraindicated? How can family physicians respond to parents who claim that they have been unjustly accused and that their adult son or daughter is suffering from "false memory syndrome"? Are pediatricians finding that their attitude toward allegations of childhood sexual abuse has changed? Are psychiatrists feeling particularly beleaguered and suspicious of patients who describe recent recall of childhood sexual abuse? What should physicians believe about related issues such as reports of widespread satanic ritual abuse and the greatly increased incidence of multiple-personality disorder?

This article outlines and attempts to simplify this complex and heated topic to enable practitioners to approach it with understanding and objectivity.

THE CHALLENGE

Ofshe and Watters[18,22] depict a huge "recovered-memory movement" of "poorly trained, overzealous or ideologically driven psychotherapists"[23] who believe that they have found a miracle cure for psychological problems. To cure these problems, these therapists believe that buried memories must be recovered. They single-mindedly persuade or coerce their clients or patients, who come to therapy with no memories of childhood violation, to remember their supposed abuse. This process is aided by self-help books[7–10] and accomplished through techniques such as hypnosis or visual imagery,[24,25] dream analysis[26,27] and group therapy.[28] As a result, charge Ofshe and Watters, clients negate their happy childhoods and functional families, and they become "monsters" who try to destroy their parents' reputations and lives and exhaust their financial resources.

Ofshe and Watters posit that most clients of recovered-memory therapists come to believe that they were molested as children; others think that they were abused by a satanic cult[29] or that they harbour multiple personalities.[30] As examples of the powers of persuasion and hypnosis, Ofshe and Watters point to the ease with which people can be led to believe that they have had past lives[31] or that they were abducted by aliens from outer space.[32] They insist on the lack of empirical evidence for, and the spurious nature of, repression. They claim that "the options for taking sides in this debate are quite unambiguous: the mind either has the ability to repress vast numbers of events, as described by recovered memory therapists, or it does not."[23] They envisage the ensuing battle between the two sides as "the therapy world's gunfight at the OK corral."[22] A more recent article by Ofshe and Singer[33] is somewhat less confrontational and sweeping, charging that a small but significant percentage of mental health professionals are reckless in their pursuit of entirely new life histories, thought to be previously unavailable because of the patients' "robust repression."

Loftus[34,35] covers much of the same ground but is less consistent in her attack. Her research explores the possibility that clients could be induced to create false memories. She uses therapists' own accounts of therapy, clients' stories, details from court cases and reports from undercover investigators posing as clients to buttress her conviction that some recovered memories are not authentic. Unlike Ofshe and Watters, she does not believe that all of the allegations based on recovered memory are false or that all of the accused parents are innocent, noting: "Research with known rapists, pedophiles and incest offenders has illustrated that they often exhibit a cognitive distortion, a tendency to justify, minimize or rationalize their behaviour."[34] She does make a compelling case, however, for a "reexamination of some of the widely cherished beliefs of psychotherapists,"[34] including the concept of massive repression and the usefulness of various treatment strategies to uncover buried trauma.

Ofshe and Loftus express extreme scepticism about the existence of secret networks of transgenerational satanic cults involved in baby breeding, infant sacrifice, ritual sexual intercourse, lifelong "programming," cannibalism and mass murder.[36,37] Police investigations have failed to corroborate complaints stemming from memories of ritual abuse recovered in therapy.[38,39]

Ofshe and Singer[33] postulate that recovered-memory therapists may lead patients to think and behave in certain ways so that they create "memories" of ritual abuse, and behave in a manner that meets the criteria for multiple-personality disorder.[40] Several authors support this belief that multiple-personality disorder is manufactured by therapists.[30,41–43]

Frankel's[44] widely read article suggests that several recent developments have generated misplaced confidence in the accuracy of long-delayed recall. These developments include work with US veterans of the Vietnam war, reports from patients with multiple personalities, new ideas on post-traumatic stress disorder and the influence of the feminist movement. Because of his growing concern about the validity of clinical methods and research reports about recalled trauma, Frankel agreed to serve on the advisory board of the False Memory Syndrome Foundation, which comprises "a body of concerned professionals who seriously question the emphatic assertions of some of their colleagues about memories of childhood trauma." Like other authors,[30,34,41] Frankel expresses concern about the use of hypnosis to retrieve memories; he emphasizes that hypnosis leads to increased confidence in the accuracy of both true and false memories and that "the use of imagery and hypnosis must be viewed as a licence to imagine and an invitation to do so; neither the therapist nor the patient can necessarily distinguish the fantasy from the fact."[44]

Ofshe argues that the recovered-memory movement is an outgrowth of feminism and that any criticism of recovered memories is seen as an attack on the women's movement. However, some support for his concerns comes, in fact, from feminist writers. One feminist psychoanalytic clinician criticizes the unidimensional focus of "incest resolution therapy."[45,46] This focus may curtail and oversimplify the therapeutic process and obscure "some of the problematic issues in separating fantasy and memory in feminine psychosexual development under patriarchy."[46] Given that society considers child sexual abuse to be more heinous and evil than other forms of abuse, neglect and abandonment, she questions whether "victims of various forms of abuse may unconsciously create a sexual abuse narrative in seeking legitimacy for their suffering."[46] In a widely read book, a feminist psychiatrist expresses concerns that "zealous conviction can all too easily replace an open inquiring attitude. . . . Therapists have been known to tell patients, merely on the basis of a suggestive history or 'symptom profile' that they definitely have had a traumatic experience."[47]

The rebuttal

Some of the responses to the charge of false-memory creation convey outrage and are as black-and-white in their defence of recovered memory as are Ofshe and Watters in their attack. Harvey and Herman[48] dispute the contention that therapists can plant fabricated memories in their clients' minds, arguing that "there is no evidence to suggest that psychotherapists have the degree of power and influence that would be required to produce this effect." Olio and Cornell[20,49] assume that the members of the False Memory Syndrome Foundation are primarily engaged in a political movement that is part of a backlash[50] against women's new-found ability to be heard and to have their claims of assault taken seriously. They stress that there are "no recovery movements, no repressed memory therapists."[49] They also point out that scientific evidence of a false memory syndrome is completely lacking and that a vast body of literature on the relation between complete or partial amnesia and a broad spectrum of trauma[51–55] is being ignored. They believe that exploitative, incompetent or overzealous therapists are the exception rather than the rule and that Ofshe and Watters' depiction of clients as "blank canvases on which therapists can paint"[49] is demeaning and outmoded.

According to Olio and Cornell,[49] three factors may influence the likelihood that patients' traumatic memories return to awareness. These are (1) feelings of safety developed in friendships, love relationships or a therapeutic relationship; (2) the spontaneous lowering of barriers to awareness as a result of stresses, illness, exhaustion, life crises or changes, or the gradual softening of defences, which often occurs during therapy; and (3) external triggers, such as media accounts or an incident in which the patient is again victimized. They emphasize that a single memory can never be taken as confirmation of childhood abuse. The hallmarks of childhood trauma, emphasize Olio and Cornell, are a combination of memories, intrusive recollections or feelings alternating with a feeling of numbness, affective fragmentation, long-standing patterns of denial and dissociation, and unexplained current difficulties.[47,56]

A report of an interdisciplinary committee of the American Society of Clinical Hypnosis[57] aims for a balanced position on the issue but also tries to correct misconceptions about hypnosis and redress the strong negative image of hypnosis that has resulted from the publicity about false memories. In the section on traumatic memory, the committee reviews more than 100 studies and concludes that the existence of traumatic amnesia and delayed recall is strongly supported by the available evidence. In particular, the report cites Feldman-Summers and Pope's[13] national survey of psychologists, which showed that 83% of those psychologists who had been abused both physically and sexually as children reported periods during which they forgot their abuse and that 47% of those with delayed recall found some evidence confirming that they had been abused. The report also mentions an interesting unpublished report by the US Federal Bureau of Investigation (FBI) that many children who were abused during the production of pornographic films later confiscated by the FBI had no memories of this abuse when they were contacted as adults.[58]

After reviewing numerous studies of hypnosis and memory and confirming the existence of both repressed memories and false beliefs about the past, the report concludes that "contaminating effects on memory are no more likely to occur from the use of hypnosis than from many nonhypnotic interviewing and interrogative procedures."[59]

Searching for middle ground

Among the many articles written to respond to this controversy, several focus on the evidence for both sides.[14,21,60] Their authors comment that the field is polarized, that there is evidence for the existence of both repressed and fabricated memories, that more research is needed and that the controversy will stimulate the "helping professions" to improve the standard of care for patients who have undergone trauma. Brown[21] and Cornell[60] note that advocates of false memory syndrome confuse the self-help literature with the much more complex and sophisticated literature on the treatment of trauma.[61,62]

An American Medical Association[63] report on memories of sexual abuse states that both sides of the argument can be supported by empirical evidence. The authors regard the issue as far from settled and stress that, when events are not corroborated, it is not yet possible to distinguish whether they are real or imagined. A statement by the American Psychiatric Association[64] touches on similar issues and expresses concern that "the public confusion and dismay over this issue and the possibility of false accusations not discredit the reports of patients who have indeed been traumatized by actual previous abuse." The statement outlines basic clinical and ethical principles for practising psychiatrists.

Because clinicians and scientists working in the field of memory are poorly informed about each other's work, Brown[21] aims to educate scientist-clinicians. After having conducted an extensive review of research on how memory is influenced by stress and suggestion, he postulates that interrogatory suggestion alone poses a risk of producing "pseudomemory." Studied mainly in a forensic context,[65,66] interrogatory suggestion[21] has the following main elements: (1) there is a context of interpersonal trust; (2) the interrogation takes place within a closed social interaction; (3) the interviewee is uncertain about what happened; (4) the questions posed centre on past events, experiences and recollections; (5) the interviewer expects definite answers and may already have an opinion about what happened; (6) there is an atmosphere of high stress; (7) the interviewer systematically uses leading and sometimes intentionally misleading questions; and (8) the interviewer meets the answers given with forceful positive or negative emotional feedback. Brown indicates that, based on the data available, 3% to 5% of people are believed to be highly suggestible[67,68] and therefore more vulnerable to the production of false memory. Spanos[69] showed that subjects who were fantasy-prone and very hypnotizable produced past-life memories when these were suggested to them during hypnosis.

To Brown's elements of interrogatory suggestion, Hammond and associates[70] add the importance of influences from outside therapy, including the influence of family and peers, sociocultural beliefs and especially experiences in self-help groups.

Brown[21] points out that no research has been done on the suggestibility of recovered-memory patients during therapy. "Memory in traumatized patients may not be readily comparable to that of normals because traumatization disrupts normal schematic memory processing, and traumatic events may be processed differently from normal memories." He relates this finding to reports that 19% to 82% of incest victims[12,13,16,71] and 20% to 65% of murderers[72–74] had more complete memories of traumatic events after a period during which they were fully or partially unable to remember the trauma.

A "middle-ground" approach to satanic ritual abuse and multiple-personality disorder could allow these controversial events or conditions to be viewed in a balanced manner. Although no proof has been found of widespread secret networks of satanic cults committing heinous crimes, there are bizarre cults[75] and there is some evidence that children have been abused by individuals or small groups in ways that include satanic themes.[76,77] Although the diagnosis of multiple-personality disorder may be produced in suggestible patients by misguided therapists, its increased incidence may also be ascribed to greater awareness of the diagnosis, the availability of specific diagnostic criteria and reduced misdiagnosis of the disorder as borderline personality disorder or schizophrenia.[78]

Issues for practising physicians

Physicians may feel caught up in this debate, buffeted by pressures from the community and compelled to take sides. Several factors may influence how a physician responds to a patient who has concerns about possible childhood sexual abuse. These factors include physicians' personal or family experience of abuse;[21] clinical experience with patients who suddenly retrieve suggestive memories[49] at times of crisis,[79] illness[80] or surgery[81] or as a result of triggers;[14,82] experience with parents who claim to be falsely accused;[18,22,35,83] and previous training, through medical school and continuing education, about sexual abuse and its after-effects. In responding to these concerns from a pediatrician's perspective, Reece[84] states that "by enhancing our knowledge base, encouraging teaching, and supporting the efforts of clinicians we will

diminish the risks of the twin errors of over- and under-interpretation of clinical material."

Bearing in mind that knowledge and research in this area are in their infancy, we can outline the current implications of this controversy for physicians.

1. Physicians must be aware of their own beliefs and biases[21] about possible trauma in patients and must remain open-minded and willing to continue dialogue on the subject.[54,57,64]
2. All physicians, and particularly those with a personal history of abuse, should be aware of the danger of overidentification with patients.[21,57]
3. When counselling patients, physicians should not "underestimate the difficulty of providing a safe atmosphere for true memories while simultaneously not supporting or creating false ones."[85] An atmosphere of free recall seems least likely to create false memories.[21,57]
4. Even physicians who are not providing counselling should be aware that they may suggest memories to or unintentionally augment the memories of the 3% to 5% of patients who are highly suggestible,[21] for instance, by telling a patient who has no memories of abuse that childhood abuse could be a reason for his or her symptoms.[6,85]
5. Physicians need to be aware of, and discuss with patients, the potential inaccuracies in delayed recall, which is often fragmented and condensed.[79] They should also be aware of and discuss the possibility that concerns about sexual abuse may veil other forms of abuse, abandonment, deprivation or neglect.[45,46,85]
6. Patients who recover memories of childhood sexual abuse are well advised to seek corroboration from other sources before contemplating family confrontations or legal involvement.[57,64]
7. Physicians should take a cautious approach to referring patients to therapists. Some people who bill themselves as "therapists" have little or no formal training;[86] as well, some mental health professionals have little awareness of their own possible biases.[87]
8. Physicians will find it helpful to understand the effect of the controversy on nonmedical systems. For instance, a pediatrician who deals with cases of sexual abuse of children may think that the legal system too readily attributes complaints of sexual abuse, particularly those affecting child-custody disputes, to the machinations of vindictive or mentally ill mothers.[88]

The need for more research

There are many competing theories about memory.[54,89] Terms such as "repression," "amnesia," "dissociation" and "forgetting" are not clearly delineated and are sometimes used interchangeably.[71,89] Most researchers endorse the constructive nature of memory and believe that various factors may interfere with remembering information at the time of initial recording, during storage or at the time of recall.[57,64,89] Many aspects of memory are unknown, including the prevalence of false accusations and the mechanisms that cause people to forget trauma and recall it much later. We do not know why memories or pseudomemories of abuse are on the increase, nor whether repressed memories always cause symptoms. Nor do we know why people differ markedly in their ability to repress or remember various types of trauma.[21,90]

Conclusion

At the core of this heated and sometimes acrimonious debate over the veracity of memories of childhood sexual abuse long buried and then recovered is the conclusion that both genuine recovered memories and fabricated memories appear to exist. Until further research provides clear evidence, physicians need to keep an open mind and respond to alleged victims and accused parents with support and understanding.

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